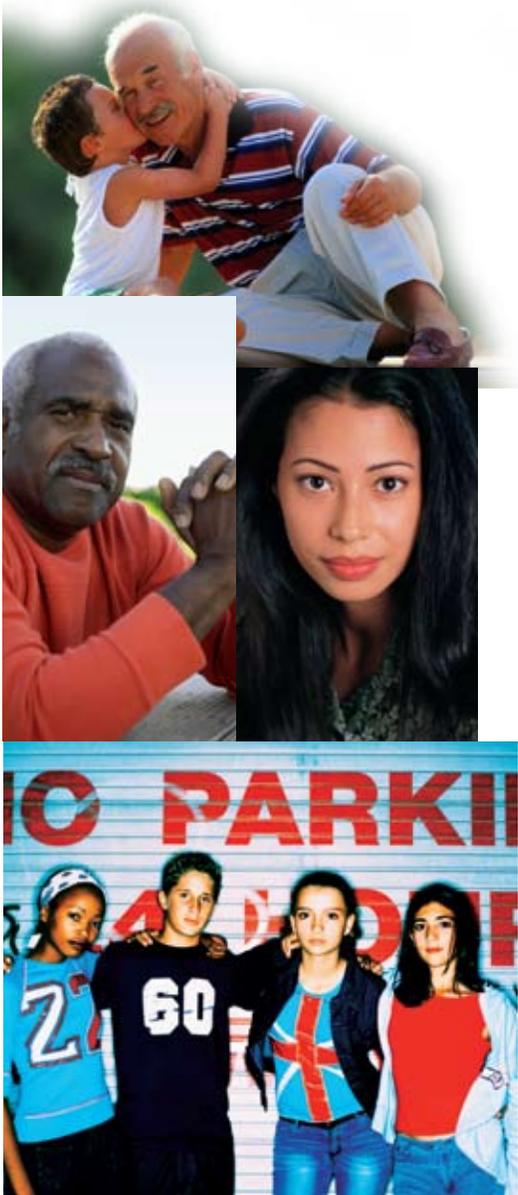




# States In Brief

## Substance Abuse and Mental Health Issues At-A-Glance



### Prevalence of Illicit Substance<sup>1</sup> and Alcohol Use

The National Survey on Drug Use and Health (NSDUH) generates state-level estimates for 23 measures of substance use and mental health problems for four age groups: the entire state population over the age of 12 (12+); individuals age 12 to 17; individuals age 18 to 25; and individuals age 26 and older (26+). Since state estimates of substance use and abuse were first generated using the combined 2002-2003 NSDUHs and continuing until the most recent state estimates based on the combined 2005-2006 surveys, Wisconsin has consistently ranked among the 10 States with the *highest*<sup>2</sup> rates on the following measures (Table 1):

**Table 1: Wisconsin is among those states with the highest rates of the following:**

Measure	Age Groups
Past Month Alcohol Use	12+, 12-17, 12-20, 26+
Past Month Binge Alcohol Use	12+, 12-17, 12-20, 26+
Least Perception of Harm Associated with Having Five or More Drinks of an Alcoholic Beverage Once or Twice a Week	12+, 12-17, 12-20, 26+

For most measures of past month and past year use of marijuana and other illicit drugs, rates in Wisconsin for all age groups have generally been at or below the national rate.

This is one in a series of brief state-based reports intended to give the reader a quick overview of substance abuse and mental health issues within a single state. The data derive principally from national surveys conducted by the Office of Applied Studies, a component of the Substance Abuse and Mental Health Services Administration. Sources for all data used in this report appear at the end.



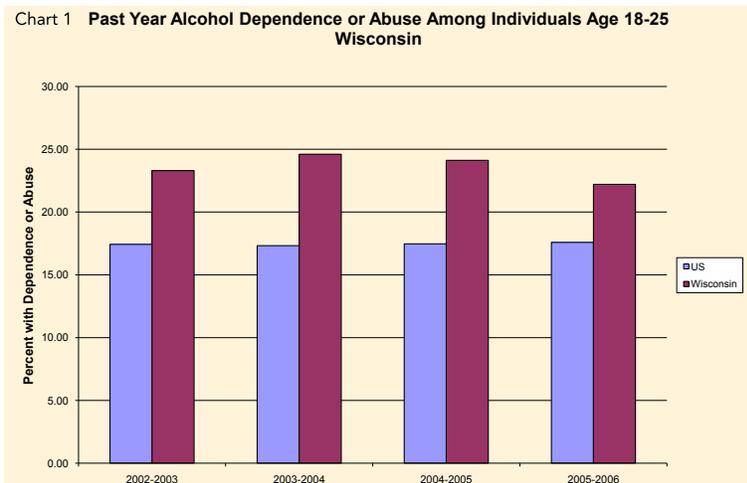


## Abuse and Dependence

Questions in NSDUH are used to classify persons as being dependent on or abusing specific substances based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)* (American Psychiatric Association, 1994).

Rates of past year alcohol dependence or abuse in Wisconsin have generally been higher than the national rates across all survey years. This is particularly true for the population of young adults age 18 to 25 (Chart 1).

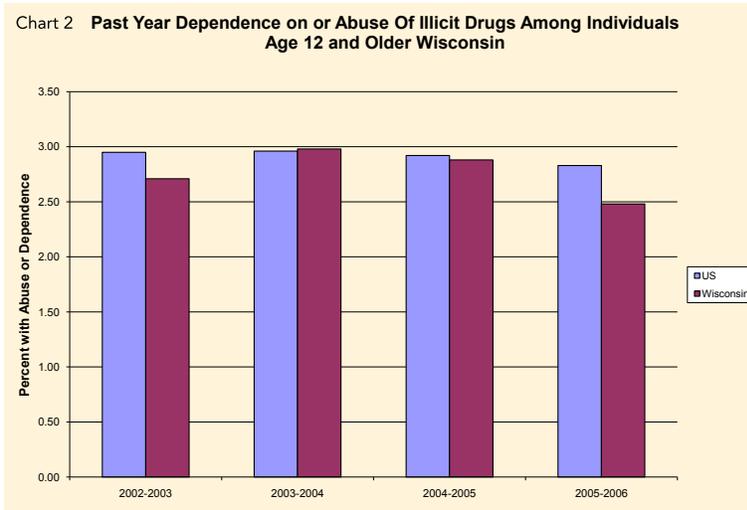
Rates of past year drug dependence or abuse, however, have generally been below the national rates (Chart 2).



## Substance Abuse Treatment Facilities

According to the National Survey of Substance Abuse Treatment Services (N-SSATS)<sup>3</sup> annual surveys, the number of treatment facilities in Wisconsin has decreased from 324 in 2002, to 290 in 2006. In the latest survey, Wisconsin had 134 private nonprofit facilities and 102 private for-profit facilities. In addition, 13 facilities are owned or operated by Tribal authorities.

Although facilities may offer more than one modality of care, in 2006 the majority of Wisconsin facilities ((235 of 290, or 81%) offered some form of outpatient treatment. Residential care was available at 67 facilities, and 15 facilities offered an opioid treatment program. In addition, 93 physicians and 59 treatment programs were certified to provide buprenorphine care for opiate addiction.



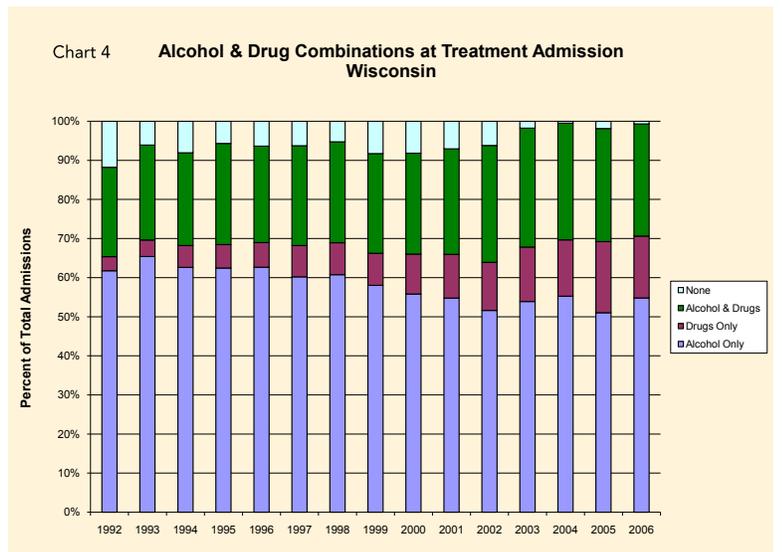
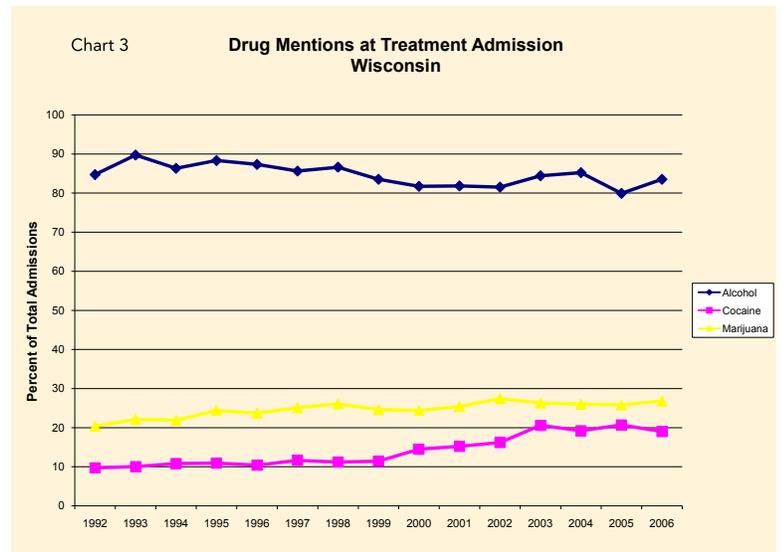
In 2006, 60 percent of all facilities (174 of 290) received some form of Federal, State, county, or local government funds, and 196 facilities (68%) had agreements or contracts with managed care organizations for the provision of substance abuse treatment services.

## Treatment

State treatment data for substance use disorders are derived from two primary sources—an annual one-day census in N-SSATS and annual treatment admissions from the Treatment Episode Data Set (TEDS).<sup>4</sup> In the 2006 N-SSATS survey, Wisconsin showed a one-day total of 17,846 clients in treatment, the majority of whom (16,558 or 93%) were in outpatient treatment. Of the total number of clients in treatment on this date, 1,974 (11%) were under the age of 18.

Chart 3 shows the percent of admissions mentioning particular drugs or alcohol at the time of admission.<sup>5</sup>

Across the years for which TEDS data are available, Wisconsin has seen a modest shift in the constellation of problems present at treatment admission. Alcohol-only admissions have declined from 62 percent of all admissions in 1992, to 55 percent in 2005. Concomitantly, drug-only admissions have increased from 4 percent in 1992, to 15 percent in 2005 (Chart 4).





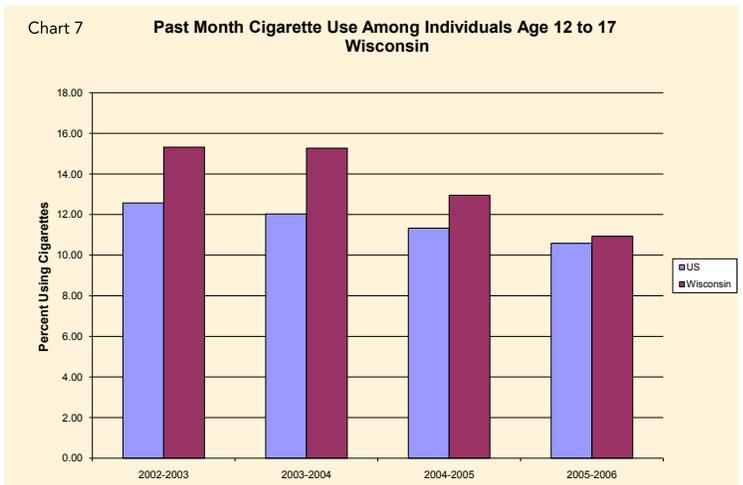
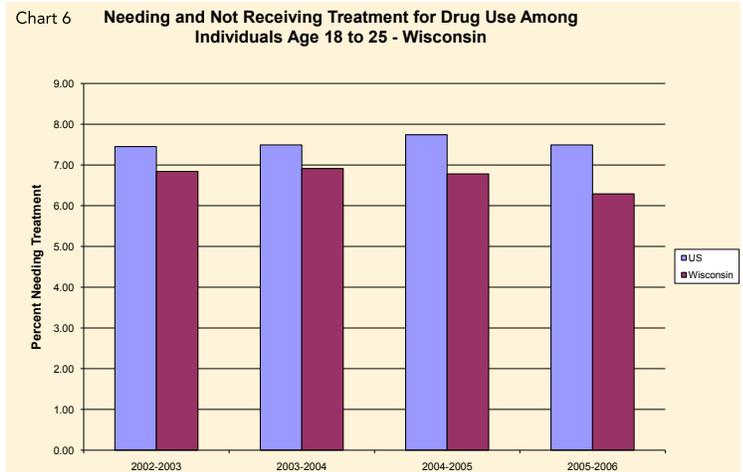
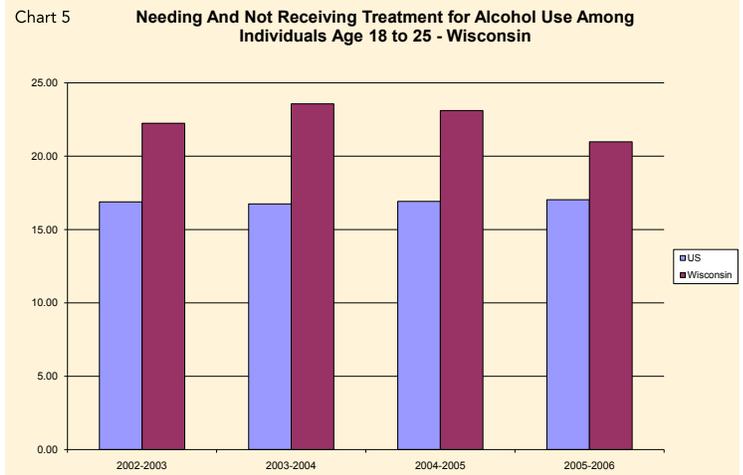
## Unmet Need for Treatment

Across all survey years and for all age groups, Wisconsin has generally ranked among the 10 States with the highest rates of unmet need for alcohol treatment. This is especially true for the population of young adults age 18 to 25 (Chart 5).

The rate of unmet treatment for drug use, especially among the population of young adults, has generally been at or below the national rate (Chart 6).

## Tobacco Use and Syнар Compliance

Rates of past month use of cigarettes among the State population in Wisconsin have generally been above the national rates. This is particularly true for underage smokers (Chart 7).

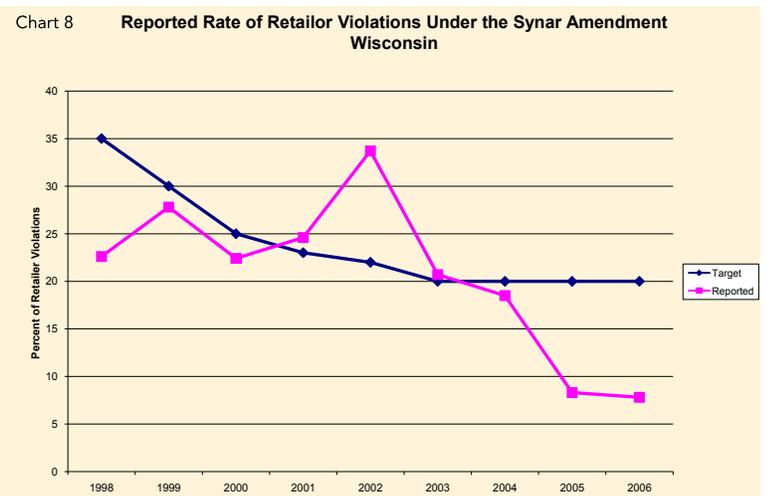


SAMHSA monitors the rate of retailer violation of tobacco sales through the Agency's responsibilities under the Synar Amendment. Retailer violation rates represent the percentage of inspected retail outlets that sold tobacco products to a customer under the age of 18. Wisconsin's rates of noncompliance with the Synar Amendment have been consistently below the target rate since 2004 (Chart 8).

### Mental Health Indicators

For individuals age 18 and older, the National Survey on Drug Use and Health measures past year serious psychological distress (SPD), an overall indicator of nonspecific psychological distress. Since 2004-2005, the survey also measures past year major depressive episodes (MDE) for the same age group and for individuals age 12 to 17. MDE is defined as a period of 2 weeks or longer during which there is either depressed mood or loss of interest or pleasure, and at least four other symptoms that reflect a change in functioning such as problems with sleeping, eating, energy, concentration, and self-image.

Rates for past year serious psychological distress have generally been at or below the national rate for all age groups, especially for young adults age 18 to 25.





## SAMHSA Funding

SAMHSA funds two basic types of grants—block and formula grants allocated to states and territories by formula and discretionary grants which are awarded competitively (Chart 9). Each of the three SAMHSA Centers (the Center for Substance Abuse Treatment [CSAT], the Center for Substance Abuse Prevention [CSAP], and the Center for Mental Health Services [CMHS]) has a unique discretionary portfolio.

### 2004-2005:

\$ 25.9 million	Substance Abuse Prevention and Treatment Block Grant
\$ 7.9 million	Mental Health Block and Formula Grants
\$ 15.8 million	SAMHSA Discretionary Program Funds
\$ 49.6 million	Total SAMHSA Funding

**CMHS:** State Mental Health Data Infrastructure Grant; Elderly Mental Health Outreach; Disaster Relief; Statewide Family Network; Post-Traumatic Stress Disorder in Children; Emergency Response; Youth Violence Prevention; AIDS Targeted Capacity Expansion—Service Capacity Building in Minority Communities.

**CSAP:** Drug-Free Communities (23 grants); HIV/AIDS Services; Family Strengthening.

**CSAT:** State Data Infrastructure (substance abuse treatment); Targeted Capacity Expansion—HIV/AIDS; Young Offender Reentry Program; Targeted Capacity Expansion—General; Pregnant and Post-Partum Women; Homeless Addiction Treatment; and Targeted Capacity Expansion—Rural Populations.

### 2005-2006

\$ 25.7 million	Substance Abuse Prevention and Treatment Block Grant
\$ 7.7 million	Mental Health Block and Formula Grants
\$ 14.9 million	SAMHSA Discretionary Program Funds
\$ 48.3 million	Total SAMHSA Funding

**CMHS:** State Mental Health Data Infrastructure Grant; Post-Traumatic Stress Disorder in Children; Statewide Family Network; Youth Violence Prevention; AIDS Targeted Capacity Expansion – Service Capacity Building in Minority Communities.

**CSAP:** Drug-Free Communities (28 grants); Drug-Free Communities—Mentoring; HIV—Strategic Prevention Framework.

**CSAT:** State Adolescent Substance Abuse Treatment; Targeted Capacity Expansion—HIV/AIDS; Young Offender Reentry Program; Access to Recovery; Targeted Capacity Expansion—General; Pregnant and Post-Partum Women; Homeless Addiction Treatment; and Targeted Capacity Expansion—Rural Populations.

## 2006-2007:

\$ 25.7 million	Substance Abuse Prevention and Treatment Block Grant
\$ 7.7 million	Mental Health Block and Formula Grants
\$ 14.9 million	SAMHSA Discretionary Program Funds
\$ 48.3 million	Total SAMHSA Funding

**CMHS:** Disaster Relief; State Mental Health Data Infrastructure Grant; Post-Traumatic Stress Disorder in Children; Statewide Family Network; Campus Suicide; Youth Suicide Prevention and Early Intervention; AIDS Targeted Capacity Expansion—Service Capacity Building in Minority Communities.

**CSAP:** Drug-Free Communities (30 grants); HIV—Strategic Prevention Framework; Strategic Prevention Framework State Incentive Grant.

**CSAT:** Strengthening Treatment Access and Retention—State Implementation; State Adolescent Substance Abuse Treatment; Young Offender Reentry Program; Screening, Brief Intervention, Referral and Treatment; Access to Recovery; Homeless Addiction Treatment; Pregnant and Post-Partum Women; and Targeted Capacity Expansion—Rural Populations.

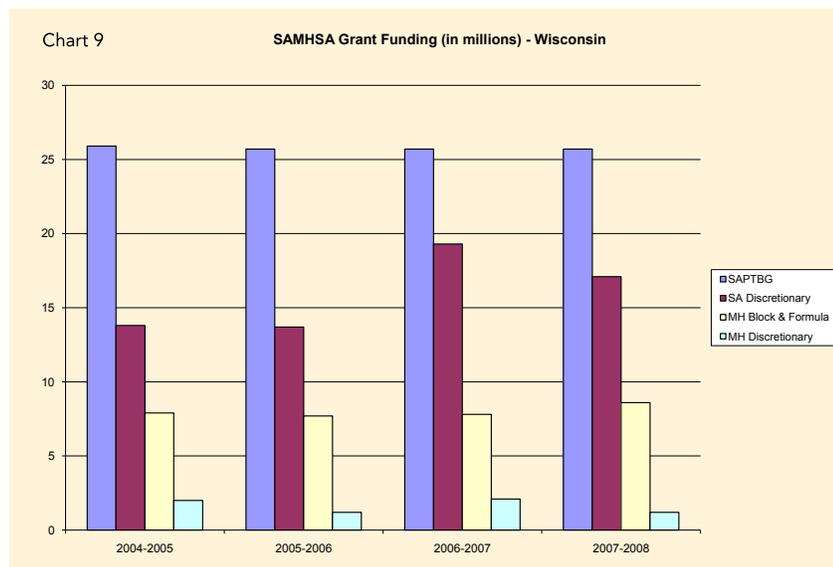
## 2007-2008:

\$ 25.7 million	Substance Abuse Prevention and Treatment Block Grant
\$ 7.7 million	Mental Health Block and Formula Grants
\$ 14.9 million	SAMHSA Discretionary Program Funds
\$ 48.3 million	Total SAMHSA Funding

**CMHS:** Statewide Family Network (mental health); State Mental Health Data Infrastructure Grant; Campus Suicide; Youth Suicide Prevention and Early Intervention; AIDS Targeted Capacity Expansion—Service Capacity Building in Minority Communities,

**CSAP:** Drug-Free Communities (28 grants); Campus Suicide; Youth Suicide Prevention and Early Intervention; AIDS Targeted Capacity Expansion—Service Capacity Building in Minority Communities; Drug-Free Communities—Mentoring; HIV—Strategic Prevention Framework; Strategic Prevention Framework State Incentive Grant.

**CSAT:** State Adolescent Substance Abuse Treatment; Young Offender Reentry Program; Access to Recovery; Strengthening Treatment Access and Retention—State Implementation; Homeless Addiction Treatment; Pregnant and Post-Partum Women; and Targeted Capacity Expansion—HIV/AIDS.





## For Further Information

A comprehensive listing of all NSDUH measures for every state is available at: <http://oas.samhsa.gov/statesList.cfm>.

Also, information about variations in incidence and prevalence of the NSDUH substance abuse and mental health measures within each state is available at: <http://oas.samhsa.gov/metro.htm>.

## Data Sources

Grant Awards: Available at <http://www.samhsa.gov/statesummaries/index.aspx>.

Facility Data: National Survey of Substance Abuse Treatment Services (N-SSATS): 2006, available at <http://www.dasis.samhsa.gov>.

Treatment Data: Treatment Episode Data Set—Concatenated File—available from the Substance Abuse and Mental Health Data Archive at <http://www.icpsr.umich.edu/SDA/SAMHDA>.

<sup>1</sup> NSDUH defines *illicit drugs* to include marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, or prescription-type drugs used nonmedically. Nonmedical use is defined as use not prescribed for the respondent by a physician or used only for the experience or feeling the drug(s) caused. Nonmedical use of any prescription-type pain reliever, sedative, stimulant, or tranquilizer does not include over-the-counter drugs. Nonmedical use of stimulants includes methamphetamine use.

<sup>2</sup> States are assigned to one of five groups according to their ranking (quintiles). Because there are 51 areas to be ranked for each measure, the middle quintile was assigned 11 areas and the remaining groups 10 each. Throughout this document “highest” refers to the 10 States in the first quintile and “lowest” to those in the fifth quintile.

<sup>3</sup> N-SSATS is designed to collect information from all facilities in the United States, both public and private, that provide substance abuse treatment. N-SSATS does not collect information from the following three types of facilities: nontreatment halfway houses; jails, prisons or other organizations that treat incarcerated clients exclusively; and solo practitioners.

<sup>4</sup> TEDS is an admissions-based system, and TEDS admissions do not represent individuals. For example, an individual admitted to treatment twice within a calendar year would be counted as two admissions.

<sup>5</sup> TEDS collects information on up to three substances of abuse that lead to the treatment episode. These are not necessarily a complete enumeration of all drugs used at the time of admission.

## Prevalence Data

Wright, D. & Sathe, N. (2005) *State Estimates of Substance Use from the 2002-2003 National Surveys on Drug Use and Health*. (DHHS Publication No. SMA-05-3989, NSDUH Series H-26). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Wright, D. & Sathe, N. (2006) *State Estimates of Substance Use from the 2003-2004 National Surveys on Drug Use and Health*. (DHHS Publication No. SMA-06-4142, NSDUH Series H-29). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Wright, D., Sathe, N. & Spagnola, K. (2007) *State Estimates of Substance Use from the 2004-2005 National Surveys on Drug Use and Health*. (DHHS Publication No. SMA-07-4235, NSDUH Series H-31). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Hughes, A. & Sathe, N. (2008) *State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health*. (DHHS Publication No. SMA-08-4311, NSDUH Series H-33). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.